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The Italian System as a Predictive Model: What the United States Can Expect from Universal Healthcare

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Chancellor's Honors Program Thesis Project

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Introduction

Within the past century, the United States has experienced many profound changes in healthcare policy. From the creation of social security and Medicare and Medicaid in the 1950's, to the most recent legislative changes under the Patient Protection and Affordable Care Act (ACA), the U.S. has slowly switched from a largely privatized insurance system to a more highly governmentally regulated one. With "socialized healthcare" becoming one of the most hotly debated topics in ongoing political campaigns and government, many Americans are left speculating as to what would be the consequences of a universal healthcare system implementation in the United States. Numerous European countries currently practice universal healthcare, and we can use their models to predict the outcomes should the United States choose to adopt similar practice and delivery methods. Italy has practiced socialized healthcare for over thirty years, and many alarming complications have emerged from their model. Through a systematic examination of the Italian healthcare system, we can foreshadow the implications of adopting a similar socialized system in the United States. This paper will first define the different types of healthcare, examine the current Italian and U.S. systems, assess the probable repercussions of national health care in the United States, and suggest a direction for the future of healthcare reform.

The Primary Healthcare Models

Mention socialized healthcare over any dinner table in the United States and you are likely to spark an ardently, albeit ill-informed, dispute. With the phrase "socialized medicine" making an appearance in almost every political debate, state of the union address, and medical

policy journal in America, the concept of universal healthcare has invaded the minds and conversations of twenty-first Americans. Perhaps one of the most contentious issues in domestic policy, healthcare is oftentimes vehemently debated without the necessary scholarly research to back up such passionate sentiments. That is why it is essential that we foremost differentiate between the various models of healthcare.

Although almost every country throughout the world has its unique system of healthcare delivery, four main models have emerged as the primary systems on which countries base their policies (Reid). The first is the Beveridge Model. In this design, the government uses a universal taxation system to finance and maintain healthcare and regulates the majority of hospitals and clinics in the country (Reid). Citizens are free from the burden of hospital bills and both private and governmentally employed doctors receive payment from the government, who ultimately dictates the amount that physicians are allowed to charge (Reid). Great Britain, Spain, and the majority of Scandinavian countries practice this mode of care (Reid).

The second model, is called the Bismarck Model and most closely resembles that of the current U.S. healthcare system (Reid). Through payroll deductions, employers provide insurance to their workers, and the not-for-profit system insures that every citizen receives coverage and care (Reid). Similar to the first model, the government controls the majority of medical costs and physician pay (Reid). Germany, France, Belgium and Switzerland are among the European countries that practice this system (Reid).

The third system, the National Health Insurance Model, is Italy's primary method for delivering care to its citizens. It is tightly regulated, and all citizens help fund the country's healthcare by paying into a government regulated insurance plan (Reid). In this not-for-profit

system, all citizens are assured care, and the costs of care are among the lowest of all four models (Reid). However, many problems often arise from this seemingly ideal policy, and we will address the specific drawbacks in a following in-depth review of the Italian healthcare system.

The final major type of system is called the Out-of-Pocket Model. In this system, citizens must pay the costs designated by physicians and medical delivery institutions in order to receive medical care (Reid). Due to the high prices of healthcare in systems, costumers are often unable to afford treatment and can go years or even entire lifetimes without seeing a physician (Reid). While it is the primary mode of delivery typically only in underdeveloped and unindustrialized countries, it is still a pervasive form of healthcare attainment in the United States. (Reid). The U.S healthcare system is a combination of all four models, and the Out-of-Pocket system helps illuminate one of the most unnerving problems currently facing American citizens who fail to obtain some form of employer-sponsored or government assisted coverage (Reid).

Although we will discuss the details of the U.S. healthcare system later in great detail, it is important to note that the Out-of-Pocket Model and its failures are the driving forces behind the past century of healthcare reform. With the 2010 enactment of the ACA and the possibility of future repeal or advancement (likely dependent upon the outcome of the 2016 presidential election) our nation faces a future transitory and experimental period of healthcare modification. With candidates and figureheads advocating Americans' rights to free, high quality healthcare, it is tempting to blindly support the idealities of a universal system. It would be extremely foolish, however, to adopt a National Healthcare Model without thoroughly examining a country which currently practices the "ideal" system which we promise our citizens. We will now examine the

history of Italy's healthcare reform and the methods by which Italian citizens receive care through their National Healthcare system.

Italy and Italian Healthcare

As the sixth most populous country in Europe, Italy ranks second on the World Health Organization's listing of the world's top health systems (Ferré et al. 2 & "World Health Organization's Ranking of the World's Health Systems"). Having practiced universal healthcare for almost forty years, Italy provides the best model for an examination of the consequences resulting from a wholly socialized healthcare system. The *Servizio Sanitario Nazionale* or SSN is the governmentally owned and operated service responsible for ensuring healthcare to the entire country (Ferré et al. 17). Similar to the current hopes of many Americans, the SSN was founded on the main principles of adequate and equal care for all citizens and controlling government spending (Ferré et al. 17). The first SSN implemented in 1978 was organized into 3 tiers: the national level, the regional governments, and the local health authorities/public and private certified area hospitals (Ferré et al. 17). Under this system, the three levels of organization each served a unique purpose: the national level was primarily responsible for taxation and planning and allocating funds to the regional level (Ferré et al. 20). The regional level upheld the requirements set forth by the national level for distributing funds to the local level and supervising the quality of local hospitals (Ferré et al. 21). Finally, the local level was in charge of directly providing both primary and secondary care within its boundaries (Ferré et al. 22). Although the system seemed theoretically straight forward and well organized, many alarming problems soon emerged. The national and regional plans were not properly executed at

the local level, and widespread politicization plagued the administration (Ferré et al. 17). Not only were the nationally designated funds insufficient to cover all of the country's healthcare needs, but substantial disparities arose in healthcare delivery between the northern and southern regions (Ferré et al. 17). These were the first indications that the devised system was flawed and needed reorganization. A series of subsequent reforms beginning in 1992, sought to decentralize power from the national government and place more control in the hands of providers and hospitals (Ferré et al.). The National Health Fund, which served as the universal taxation system and monetary distributor, was abolished which reallocated a great deal of the fiscal responsibilities to the regional and local levels (Ferré et al. 18). The following two decades were characterized by similar reforms, all aiming to shift the concentration of power from the central government to the individual regions.

The current SSN is still organized in a three-tier system. Through the ministry of health, the national level still controls the majority of planning and fund distribution, but the regional levels now hold the power to enact their own legislation for financing and delegating the responsibilities of the local level providers and hospitals (Ferré et al. 20-22). The system receives funding through a tax system called the *Imposta Regionale Sulle Attività Produttive* where employers contribute for the benefit of their employees and the self-employed pay through their taxes ("The National Health Service: The public health system in Italy"). All citizens register with a local health authority and physician, and receive a healthcare card and number, which allow them to seek care with that local provider ("Healthcare in Italy"). Inpatient and outpatient costs are covered, including visits with primary care specialists, surgical costs, and even dental costs ("Healthcare in Italy"). However, modest co-payments are often required for medications, lab tests, and emergency room care that is deemed "unurgent" (Ferré et al. 60). Finally, private

insurance (Voluntary Health Insurance, VHI) offers an alternative to the public healthcare options provided through the SSN (Ferré et al. 61-62). It can be purchased by individuals or supplied to employees and their families by employers (Ferré et al. 61). The system appears ideal; registered citizens are ensured affordable, if not completely free healthcare, but also allowed the option of choosing privatized insurance should they so prefer. So one must ask, why is Italy ranked second among all nations by the WHO for the world's top healthcare systems, yet Italians are still highly displeased with their overall quality of received care?

Problems with Italian Healthcare

While two decades of reform have abetted some of the original problems of the SSN, adopting a national healthcare system, has proved a complicated and messy transition. The model appears ideal in theory, but its ground level implication has revealed it as an ultimately failing system. The original goals underlying the instigation of a governmentally regulated national healthcare model were to curb healthcare spending, and ensure that every Italian citizen received adequate and equal care ("The National Health Service: The public health system in Italy"). However, twenty years after the instatement of the first SSN, poor governance, disorganization, and uncontrolled spending continue to plague the system ("The National Health Service: The public health system in Italy."). In addition to administrative and financial glitches, many Italians believe their quality of care to be largely insufficient. In 2011, one in three Italians reported being dissatisfied with the national healthcare system (NHS) and its ability to deliver equal, adequate treatment throughout the country (De Belvis et al. 14). The NHS has failed to

live up to its predicted success and any country looking to adopt a similar model should consider the alarming financial and delivery problems facing Italy today.

One of the main goals of the Italian SSN was to ultimately lower the nation's healthcare spending. However, in 2012, Italy ranked among the world's top countries for per capita debt, and a substantial portion of those incurred costs can be attributed to uncontrolled regional healthcare spending (Maris & De Belvis et al. 11). From 2001 to 2010, regional healthcare spending deficits exceeded 38 billion euros (De Belvis et al. 11). This demonstrates the ministry of health and national tier's inability to exert control over the regional level's spending, and illustrates the disorganized and poorly regulated system's delivery. Following the debt accumulation, Italy implicated a series of strict healthcare regulations through the 1010-1012 Health Pact in an attempt to contain regional spending. (De Belvis et al. 12). The consequences are disconcerting. Both families and individuals experienced a decrease in disposable incomes as co-pays and business taxes increased to help fund the national healthcare system (De Belvis et al. 13). In addition, hospitals were required to reduce the number of hospital beds to a meager 4 beds per 1000 regional residents, cut down on the time patients could be hospitalized, and even reduced admittance numbers altogether (De Belvis et al. 13). From a financial standpoint, these methods prove successful for reducing healthcare spending but are coming at a high price with regards to the overall quality of healthcare. Dental care has become increasingly difficult to access, especially for middle and lower classes, and mental disorders are reportedly on the rise (De Belvis et al. 14). In 2011, one in ten Italians reported delaying surgical operations due to an inability to pay the high copays required for treatment, and the current crisis is only getting worse (De Belvis et al. 13). Following the implication of the national healthcare system, Italians have reported a noticeable and alarming decline in the apparent quality of care, and revealed

little confidence in their healthcare system's future sustainability (De Belvis et al. 14).

Unfortunately, the system was financially unsound from the start. The national tier failed to control regional spending, and the incurred debt sent Italy into a state of healthcare crisis. The major consequences of the subsequent cost containment measures were a decrease in overall quality of care, and a country with little faith in its national healthcare system.

The second goal of implementing a national healthcare system was to provide affordable and accessible treatment to all Italians ("The National Health Service: The public health system in Italy"). However, this has also proved exceedingly difficult to accomplish. According to a survey conducted in 2010, one of the leading concerns of Italians was the broadening disparities in healthcare quality between the northern and southern regions (De Belvis et al. 15). Although the national level distributes equal funds to the regional tiers, it is ultimately the regional committees that designate further utilization and distribution of funds (Ferré et al. 21). This regional level responsibility was the result of the early reforms of the SSN, but has ultimately produced inconsistencies among the regions in the availability and quality of treatment (Ferré et al. 24). The northern and southern regions of Italy differ markedly in their quality and delivery of public care, with northern cities encompassing far superior facilities than the South (Bezzone). Although public hospitals are reportedly over crowded across the country, the problem is augmented in the North, where southern residents migrate to seek better care (Shafran). This results in long waiting lines which can delay required treatments for weeks or even months (Shafran). All things considered, Italy's national healthcare system is currently failing to accomplish the main goals underlying its implementation. Uncontrolled spending and wide discrepancies in care across the country remain trademarks of Italy's model as well as striking warning signs that the system simply doesn't work. So what implications can this have for the

future of United States healthcare? In the upcoming sections we will focus on some of the most recent and significant changes to the U.S healthcare system, address the effectiveness of the latest reforms, and finally correlate the changes taking place within the Italian healthcare system the future of the U.S.'s healthcare.

United States Healthcare System Reform

Like Italy, the United States has, for over a century, been in a transitory period of healthcare reform. Although universal healthcare was first proposed at the start of the twentieth century, it failed to gain the public and policymaker support necessary to make it a reality (Oberlander 586). During the 1940's, unions pervaded working-class America, and the demand for healthcare benefits led to the materialization of employer-sponsored private insurance (Oberlander 586). The working population received healthcare benefits from their employers who held agreements with the insurance companies which set premium, deductible, and copay costs (Oberlander 586). However, a great deal of the population, including the unemployed, elderly, and disabled, were unable to obtain affordable coverage. In 1965, the U.S. government adopted a leading role as a shaper of healthcare policy through the enactment of Medicare and Medicaid (Oberlander 586). With the execution and success of these programs, the elderly, disabled, and underprivileged populations were assured access to medical care (Oberlander). However, in the following decades, healthcare costs skyrocketed, and many Americans lost employer-backed coverage, or were denied insurance altogether by reason of preexisting conditions or high risk assessment (Oberlander 587). As the number of uninsured Americans rose from 31 million in 1987 to almost 50 million in 2010, healthcare reform became one of the

highest priorities on the legislative agenda (Oberlander 587). Throughout much of the late twentieth century, the U.S. had ranked number one as the world's leader in per capita healthcare expenditures with little to show for it in regards to quality care, and reform became inevitable (Schieber et al. 24)

However, conflicting sentiments regarding the government's role as a regulator of healthcare policy made any type of substantial reform exceedingly difficult. On one spectrum, Americans believed that healthcare and medical treatment were rights that all citizens should be guaranteed by the government. On the other end, was the belief that the government should stay predominately removed from influencing healthcare policy. When the Patient Protection and Affordable Care Act (ACA) emerged in 2010 under the Obama administration, it was undeniably the most significant healthcare reform legislation that the country had ever seen. It also marked the most prominent role that the U.S. government had ever assumed as a shaper of healthcare policy. Under the ACA Medicaid was expanded, employer and individual mandates were enacted, and new guidelines for the insurance market were put in place (Oberlander 588). The legislation is incremental in design—its specific regulations were enacted over the course of a six year period with its full implications projected to take effect in 2017 (Blumenthal et al. 2453). So with the complexity of the new legislation, many questions have arisen in the political and public domain. What are the ACA's implications for ensuring medical coverage and controlling U.S. healthcare costs, and is the ACA a successful model for positive healthcare reform?

Current U.S. Healthcare Under the ACA

Similar to the ideals that drove the instatement of universal coverage in Italy, the Patient Protection and Affordable Care Act was created with the intent to ensure that U.S. citizens (who could not otherwise) received adequate medical care. Its scope is extremely in-depth and far reaching so we will focus primarily on the most significant changes that it has had on government spending and healthcare availability. First and foremost, the ACA required that all citizens obtain some form of healthcare insurance coverage or pay a fine in the form of taxation (Blumenthal et al 277). This is what is referred to as the “mandate.” The mandate came in two forms—one form required that businesses of a certain size provide their employees with benefits, and the other required individuals who did not have some form of private or employer-sponsored coverage, to purchase a plan (Blumenthal et al 279). In order to make coverage a reality for those who could not previously afford it, the U.S. government now provides subsidies to qualifying citizens, allows children to remain on their parents’ insurance plans until they are twenty-six, and gives all states the option to expanded Medicaid (paid for in full by the government) to include any adult that is at or below 138% of the poverty level (Blumenthal et al 279). It has also reshaped the insurance market by creating a set of national standards for insurance companies (Blumenthal et al 278). Insurance companies are subjected to certain national standards for plan options as well as pricing and are now required to cover at-risk individuals and those with preexisting conditions (Blumenthal et al 277). Although co-pays, deductibles, and premiums can still vary among the different plans, they are subject to price caps, and must cover an established range of benefits (Blumenthal et al 276).

The ACA also encourages hospitals and physicians to shift from fee-for-service payment systems to pay-for-value programs (Blumenthal et al 2453). This transition encourages

healthcare providers to increase the quality of their administered care while reducing overall expenditures (Blumenthal et al. 2453) Providers are offered incentives for lowering readmittance rates, decreasing instances of hospital-acquired illnesses, and becoming “Accountable Care Organizations,” which help ensure quality and comprehensive care to Medicare recipients (Blumenthal et al. 2454). Many of these payment reorganizations are designed to shift healthcare delivery from a predominantly diagnostic objective to a more preventative approach.

So we address the ultimate question as to whether or not the ACA is succeeding as a positive healthcare model for the United States from a coverage and cost standpoint? By May of 2014, over 20 million previously uninsured Americans had received coverage, and it was projected that by 2017, the ACA will have reduced the number of uninsured Americans by over 25 million (Blumenthal et al 277). Also, over the past five years, the U.S. has experienced an overall decrease in healthcare expenditures (Blumenthal et al 2456). However, it is too early to discern whether the decrease in per capita spending is a result of the ACA or other factors such as the 2008 recession (Blumenthal et al 2456). Therefore, at this time it is impossible to determine the definitive financial success of the ACA’s programs from a national expenditure standpoint.

So, are we able to truly consider the ACA an overall success? The answer is, yes, so far we can. To this date, the ACA has proven a successful model for providing Americans with affordable healthcare coverage while keeping government healthcare spending at a moderate level. Although some might refer to the ACA as universal healthcare, it is ultimately not considered a “universal healthcare system.” It lacks the basic, defining characteristics of other national healthcare plans, which are characterized by universal taxation and the government guarantee that all citizens will receive care. It is a complicated, extensive piece of legislation and

far from the more straightforward and comprehensive National Healthcare Model that we described earlier. With that in mind, there are many politicians and American citizens who speak out against the ACA (and all its complexities) and instead, support a simpler, all-encompassing national care model similar to the one currently in effect in Italy.

Italy's National Healthcare Model provides is an ideal example of a failing system and it is unnerving that universal healthcare has nonetheless gained such fervent support in the U.S. within recent years. There are already some alarming problems emerging from the ACA that foreshadow possible future complications should the U.S. continue to seek a fully universal system. So we now come upon the final question of this discussion: should the U.S. adopt a national healthcare system given what we have seen transpire from the Italian national healthcare model? And if not, what is the best direction for future U.S. healthcare?

Learning from Italy: Italy's Problems Projected into the U.S.

For the upcoming 2016 presidential campaign, healthcare remains one the most controversial issues facing the political agenda. When former democratic political candidate Bernie Sanders was asked in a CBS Face the Nation 2015 interview about his views on U.S. healthcare he responded, "I happen to believe that in a democratic, civilized society, all people should be entitled to health care as a right. Is this a radical idea? No, it's not. Every other major industrialized country on Earth does the same" ("Bernie Sanders on Health Care"). Italy is included in this overreaching category of industrialized countries, yet the fact that its healthcare system is highly inadequate does little to slow Americans' growing support for national healthcare. While the Affordable Care Act is currently functioning as a successful healthcare

model, pursuing a more universal system would prove disastrous to the country's budget and health status. We should look to Italy's model as a foreshadowing of the barrage of repercussions we could expect with the instatement of a universal healthcare system. However, there are some major differences between the U.S. and Italy that would further increase the chances that a National Healthcare Model would fail the country. In contrast to Italy, the U.S. has a higher per capita debt and far vaster land area, and would essentially experience many of their current problems but only on a much grander scale. Forth most, the country would undergo a marked decline in the availability and quality of medical care, leading to dissatisfaction among physicians and citizens alike. Furthermore, large regional discrepancies would arise among the fifty states, and decentralization would likely cause superior facilities to become aggregated in urban areas. Also, instead of controlling healthcare spending, the transition to a National Healthcare Model would increase the U.S.'s current debt accumulation and launch the country into a period of strict legislative and delivery reform.

The largest consequence the U.S. would face, should it adopt a universal system, is nationwide decrease in the availability and options for medical care. In Italy, some of the most commonly reported problems are the low accessibility to adequate facilities and long waiting lists to receive treatment ("The National Health Service: The public health system in Italy"). Within the U.S., increasingly limited access to care is also a rising concern. Some argue that while the governmentally controlled market places created by the ACA are more affordable, they limit consumer's options for selecting providers (Blumenthal et al. 2452). Under a universal healthcare system, these options would become further restricted—remember, cost containment is one of the principle driving forces of healthcare reform. The U.S. national government and state governments would establish a set budget for the management of a limited number of

hospitals. Current providers would likely experience a drastic cut in salary, be forced to adhere to new healthcare standards, and considerably alter their delivery methods to adhere to new standards. I predict that this would result in a marked decrease not only in the number of current practicing physicians, but also the number of bright, ambitious future generation willing to enter the medical field. Sure, the U.S. could continue to have a private sector of medicine (such as is seen in Italy) —this is the route that the best of the best doctors will go, because they can—but these options would be substantially more expensive than the government provided opportunities to care. However in reality, the majority of the population would be unable to afford such options, and would turn to the free care provided from governmentally run establishments. Like Italians, American citizens would likely be placed on long waiting lists to receive treatment from the limited number of available. Americans would be left with the daunting dilemma which many Italians currently face—to place their name on a waiting list to seek fully covered (but lower quality) care at a governmentally run institution, or pay extremely high out of pocket costs to see private providers.

The second consequence that the U.S. would face with socialized healthcare would be widespread discrepancies across the nation in the quality of care. Because the United States is so vast in land area, we would expect the U.S. government to adopt a decentralized scheme similar to the reforms that restricted the Italian SSN in 1992. The national government would create a set of guidelines that must be met by all hospitals and providers, but would devolve a great deal of power to the states to further establish specific regulations as they see best for their own unique state and regions. In Italy, disorganization among the national, regional, and local levels of government is one of the leading causes for healthcare inconsistencies throughout the country ("The National Health Service: The public health system in Italy"). Furthermore in the southern

regions, financial mismanagement and bureaucratic fraudulence has caused a critical inadequacy in available quality care ("The National Health Service: The public health system in Italy"). The U.S. is significantly larger than Italy, and it is naïve to assume that the different states would not employ somewhat unique systems of care. The quality and availability of medical services that would be offered in—for example—New York would be very different per say than in Montana. Also, the sad reality of government is that administration is easily corrupted by both special interests and personal greediness, and I predict that all of these factors would leave the door wide open for massive discrepancies in the nationwide delivery of healthcare to evolve.

Finally, should the U.S. adopt a universal healthcare system, the country would likely incur a substantial amount of national debt. Although one of the main goals of healthcare reform in the United States is cost containment, will the implementation of a fully national healthcare system reduce healthcare expenditures? Following the 1978 healthcare reform in Italy, lack of adequate government funding caused large public deficits and debt for which the government was forced to compensate (Ferré et al. 17) Ambiguities regarding both local and regional spending powers were regarded as the primary causes of uncontrolled health care spending which peaked in 2004 at 6.42 billion euros (Ferré et al. 17 & De Belvis et al. 11) The country rapidly incurred much greater costs than originally expected and the following four decades following the implementation of the first SSN were characterized by strict cost containment regulations (Maris & De Belvis et al. 12). In 2012, Italy had accrued a per capita debt of approximately \$39,611 U.S. dollars and had an overall debt to GDP ratio at approximately 100-120% and—a plight which was predominantly attributed to high regional healthcare expenditures (Maris & De Belvis et al. 11) The main cause of the high rises in Italy's healthcare spending can be traced back to the failure of the national level of the SSN to properly designate

the necessary funds to the regional administrations and local providers (Ferré et al. 17) This is a flaw in the national healthcare model's design that is caused by a discrepancy in planning and ground level implementation. Without precise budgeting at the national level, and strict regulations for fund allocation at the regional level, this system is very likely to leave the local healthcare providers with insufficient funding. Now, if Italy, a country that comprises approximately $294,140 \text{ km}^2$, cannot ensure strict regulations throughout its regions, how can we expect that the United States which covers more than $9,147,420 \text{ km}^2$ (nearly five times the area of Italy) could possibly hope to maintain local level healthcare spending under strict jurisdiction from a national administration? ("Land Area sq. Km "). For this model to work, the U.S. government would have to accurately estimate the funds that would be designated to all fifty states (and the regions within those states) for the comprehensive coverage of citizens' medical needs. It would then need to implicate a form of taxation to collect these funds, and devise a system for allocating them fairly among the states. But here is the catch. It would be painstaking difficult (if not impossible) during the first years following implementation of a National Healthcare Plan to accurately predict the amount of money each unique state and region would need to properly ensure the comprehensive medical care of its citizens. For a country as large and diverse as the United States, the occurrence of deficit and debt accumulation from improper budgeting would be inevitable.

The Future of Healthcare for the U.S.

The final point that I want to address is the reality that every human being should have access to medical care. Whether you are rich or poor, sick or healthy, living in a big city or a

small rural town, it is undeniably pertinent that you should be able to obtain treatment at a reasonable cost. However, what I wish illustrate over anything is that this is *not* the same as claiming that everyone is entitled government provided free healthcare. In fact, the two goals are entirely contradictory and cannot exist together. That is why it is so important to study other countries' models, examine the consequences of their systems, and attempt to create a model that will best serve the healthcare needs of a specific nation. Through my research, I have found that there are both benefits and costs to the Affordable Healthcare Act here in the United States. I believe that as it is functioning right now the Affordable Care Act is doing a fairly good job at containing the costs of healthcare and improving the quality of treatments that Americans are receiving. However, there are still many areas for improvement. As highlighted in the interview with Dr. Shannon Sorah, patients need to be accountable to a greater extent for their overall health and wellbeing. In fact, in a 2013 survey conducted survey among U.S. physicians, 98% of respondents agreed that patients have somewhat to major responsibility for lowering healthcare costs, and this can best be accomplished through the practice of healthy lifestyles (Tilburt et al. 382) The ACA and future direction for reform highlights the importance of value-based rewards to physicians for high quality work, but I believe that this is nearly impossible to quantify and regulate (Burwell 899). Instead, patients should be rewarded. We should limit incentives from the standpoint of healthcare delivery and create a system that rewards citizens for taking an active role in maintaining their own personal health (such as abstinence from smoking and excessive alcohol usage, regulation of a healthy body weight and nutritious food consumption, and active lifestyles). Prevention is essential to the success for future healthcare reform and financial incentives for citizens who have taken an active role in maintenance of their health could significantly reduce the chance for the development of certain conditions later in life.

From a delivery standpoint, it is of utmost importance that the United States continues to have a private sector of medicine. Having both a privatized and public sector of healthcare delivery simply does not work. Privatized healthcare promotes competition among hospitals and providers alike, and will be much more successful at promoting high quality care than a universal system could. Hospitals and physicians would be rewarded for their excellence by the attainment of a distinguished reputation and subsequent by high attendance rates. With that being said, there are certain standards that providers should continue to be required to meet. This is vital to reduce discrepancies in medicine that can arise due to location, and limit the possibility for underserved areas to experience an inadequacy in quality care. In my opinion the ACA's creation of certain delivery criteria should be seen as a positive alteration to the U.S's healthcare system and continued throughout future years of reform.

Finally, as a future physician, I believe in the importance of listening to the concerns and suggestions of practicing doctors to fully understand how healthcare policy takes place during ground level implementation. The interviews conducted with Dr. Massimo Di Febbo and Dr. Shannon Sorah were vital to understanding the problems associated with different models of healthcare, and were instrumental for revealing the consequences associated with the adoption of a universal healthcare system. Prevention should be the driving concept surrounding future reform, and all upcoming policy changes should be centered upon the notion that individuals and physicians are jointly responsible for maintaining health. High quality healthcare is a right that should be granted to all U.S. citizens, and the best way to achieve this goal is continue to hold hospitals and providers to a level of excellence, but also to allow them to run their institutions and practices with the methods that they know will best serve their patients. Healthcare is a right that all U.S. citizens should be able to attain, but that does not mean that this right will be free.

As Americans we must take an active role in the maintenance of our personal wellbeing, purchase an affordable coverage policy offered now through the ACA or obtain employer-provided coverage, and most importantly understand that we cannot expect both free and high quality care, it just simply is not possible.

Dr. Massimo Di Febbo, MD

“Opinions on Healthcare”

Q: How can Italy be ranked second for healthcare in the world, and yet still be facing so many financial and delivery problems?

A: The quality of care is not always proportional to the budget or other economic opportunities available; Italy is the top places for health care in the world thanks to the training of its health personnel (the degree courses in medicine is very long - about 11 years including the specialization - and even nurses must earn a degree for a period of three years) in international research group there is always an Italian doctor or researcher is always included as part of the group.

Q: Can you explain the national healthcare system from an Italian's point of view?

A: The National Health System as well as it is conceived today entered into force in Italy in 1978. It guarantees health care and medical / nursing care to all residents in Italian territory. Most hospitals, within a province, are grouped to form the ASL (local health) that should work together like real companies.

Every ASL has its own functional and administrative autonomy through the presence of a General Manager, an Administrative Director and a Medical Director.

The financial resources come from state reimbursements for medical services and various local taxes.

Q: What have been the biggest problems with the system from a healthcare delivery standpoint? Such as long waiting lines, not enough hospital beds, disparities in care in different regions.

A: The main problems of the operation result from the disparity of available resources of the various regions, both in infrastructure and economic terms. The regions with a higher GDP have greater resources compared to poorer regions (especially those of the south Italy). Some regions which have over the years continued to accumulate debts due to the management of the health system. Commissioners at the state level drew up a recovery plan for the multiannual hiring freeze and reduction of hospital beds and that unfortunately it leads to an increase in waiting lists and health migration to other regions. One of the main problems of the rise in health expenditure is the fact that there are no (it is attempting to do so now) uniform plans for purchasing health products and services; for this reason it is difficult to manage and standardize health care spending in the various regions: for example, a ceramic hip replacement might cost 284 € in one region and 2,575 € in another, an increase of 806%.

Q: As a physician, what are the main things that you like about having national health care?

A: From the standpoint of being a physician, I can say that our NHS is among the best in the world because they guarantee excellent care to anyone virtually without spending anything (whether it be a heart surgery, or care for chronic conditions etc.).

The downside lies in the fact that now, to ensure these levels of healthcare, spending has risen to around 105 to 110 billion euros per year, and every year there are always cuts on

services provided by the SSN in order to provide savings, such as some types blood tests, instrumental tests such as MRIs etc. prompting users to turn to the private providers.

Q: What are the things you least like?

A: The things that are not like the ones listed above: the disparities present in the various regions, the very long waiting lines for some basic services, the fact that the appointment of the Directors General of the *Aziende Sanitarie Locali* (ALS) is appointed in a political manner rather than from a fair job search or competition.

Q: What in your opinion, needs to be done to improve the current healthcare system in Italy?

A: In order to improve the NHS first need to standardize the costs, you would have a reduction of expenditure by about 30% from what it is currently; it would be beneficial to eliminate a number of services covered by the SSN and resold to private sector doctors such as x-rays, ultrasounds, analysis, sports physician visits, etc. to improve the waiting lists. Increase the prices of code white and green of the emergency room (all those people who go, instantly, to the emergency room, but you actually have solved diseases locally).

Note: code white-there is no urgency associated with your condition, code green- low urgency and minor traumas, with minimal pain

Q: Is private insurance common or are most Italians just using the government's healthcare?

A: In recent years, Italians have always turned more to private care especially in the low-welfare impact performance as instrumental tests, basic medical examinations, the basic surgeries especially because in the public sector there are very long waiting lines for physiological interventions of this type.

Q: What are the main benefits of private care and can many people afford it?

A: The benefits of private care are the speed of the performance, the greater courtesy of the staff and almost always the high professionalism of the private doctor (which in Italy has to compete with an excellent public system for the type of services provided).

The problem of the cost, especially for basic services, is almost nonexistent as the private rates are competitive compared with the NHS costs, which over the years have soared to meet costs continuously imposes an additional expense (sanitary ticket) from the national government for the execution of any performance.

Q: Do Italians like their healthcare system from what you see?

A: The Italian nature is to complain, but I think most of them value the NHS, especially those who had the chance to see what healthcare was like in other places.

Q: Are doctors compensated enough for their work?

A: Physicians, like other professions, are underpaid; for example, I believe that a hospital doctor American is paid about 3 times more than an Italian.

Q: Is it easy to get a job after medical school? Is there a high demand for doctors?

A: The Faculty of Medicine is one of the few in Italy that still manages to provide an almost immediate workplace, in the public or in private sector. However, in the last 6-7 years, due to the health deficit and lack of new doctor admission and turnover, many young physicians have had, and still have, difficulties making employment contracts and, for the first 7-8 years of operation, work is almost always temporary.

Q: Should the U.S. adopt a national healthcare system?

A: NO because I think as it is structured today's American society a Public Health System would be an expensive process and unsustainable, indeed I think in a few years the Italian health system will evolve towards a mixed public / private system with certain services (primarily surgical) guaranteed by the state and other granted only after purchasing insurance because unfortunately it is impossible to serve everyone due to unobtainable economic resources and economic trends that have characterized the last decade.

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Dr. Shannon Sorah, DO
“Opinions on Healthcare”

Q: How can Italy be ranked second for healthcare in the world, and yet still be facing so many financial and delivery problems? Not to mention widespread dissatisfaction among Italians?

A: I have many Italian friends and I have heard horror stories about their healthcare system. Anytime you let the government have control or pay for something, they are going to be more interested in saving money. They are not in touch with reality; they are simply looking at numbers, not patients.

Q: What have been the biggest problems with the system from a healthcare delivery standpoint? Such as long waiting lines, not enough hospital bed, disparities in care in different regions.

A: With a national healthcare system, there will be long lines, wait for your surgery, and they ration healthcare.

Q: As a physician, what are the main things that you like about having national health care?

A: I don't think I like anything about a national healthcare system.

Q: What are the main things you dislike about national healthcare?

A: Things I dislike about national healthcare: the government trying to tell me how to practice medicine, it's not free like people thought-someone has to pay for it. Since the

onset of the Affordable Care Act, I have more paperwork to do for the government and I have to turn in this paperwork to show them that we did certain "measures" that they feel are important. At the beginning, the doctor's in this nation did so well, that the government decided to change those measures and come up with new ones. The government developed the Pay for Performance program, basically they are finding more ways to not pay us. It is more difficult to take care of patients because of the computer work and paperwork. Most of the measures are ridiculous. Some of the measures are impossible to win, such as, on a post-operative survey the patients are called and if they don't give you an "excellent" rating, you aren't doing a good job and your scores decrease, even if they give you a very good score. When you can't meet your goal because of a low score in this category, you don't get paid as much. Also, they just released a way they are going to score hospitals. It is the most unbelievable and confusing way to score hospitals that all physician groups are writing the governments and protesting. If you score well in all of the pay for performance categories and the HHCAPs, (Hazard Analysis and Critical Control Point) you can still receive a poor ranking. It is unfair and not useful and will confuse the public.

Q: What in your opinion, what changes should take place to improve the current healthcare system in the U.S.?

A: To improve the current healthcare system in the U.S., we need more primary care physicians, and we need to really focus on health and prevention. We should put money into this and look into why Americans are so unhealthy. Our food system needs an overhaul to facilitate healthy lifestyles.

Q: Do Americans feel like they have adequate choices for choosing their medical care, or are the options very limited?

A: I feel like in American, there are many options even if you don't have health insurance but you have to be pro-active. You have to ask around, seek out the free medical screenings and clinics. You have to take responsibility of your health.

Q: What are the main benefits of private care and can many people afford it?

A: Private healthcare, when your employer provides you insurance, allows for preventive care. You can have checkups, prevent disease or catch it early. In America, we "take a pill" for everything rather than trying to be healthy and prevent disease. Also, since the ACA (Affordable Care Act) began, people were not allowed to keep their current insurance, they couldn't keep their same physician a lot of times and it became more expensive! What happened is that every employer had to move his or her group to a compliant insurance plan. Those plans have significantly higher deductibles and out of pocket costs. It essentially punished the people who were working and had insurance already.

Q: Is the ACA saving money while keeping the cost of medical care reasonable and the quality high?

A: Every day I have meetings about how to save money. I am all for that but we are going to cheaper equipment and maybe it doesn't work as well. Another ACA effect is that many companies that were manufacturing generic drugs used in hospitals, decided to

quit because there was no profit. New companies buy the rights to the drugs and begin manufacturing them. The new company decides they want to make money and since they are the only ones manufacturing this drug, they increase the price by 200-400%!!!! Many times this happens without any warning to the hospital. I don't call that affordable healthcare

Q: Are doctors compensated enough for their work and time spent schooling?

A: All I can tell you is that I spent 12 years after high school doing my training, I worked 80 hours a week or more during my internship and residency, I had unbelievable amounts of stress during training, I had to take a written and oral exam, I had to work for 3 years before I made partner in a group, and I had over \$200,000 in school loans. The average physician has over \$300,000 in debt now when graduating. By the time a physician starts working and actually making good money, they have lots of debt to pay off and they are usually about 34 years old which means they have lost many years of making money just to go to school. Once you start work, you have to have malpractice insurance. I pay over \$30,000 a year for this. I feel like if there was less of a chance of a lawsuit, less risk, I would not only order less tests (and save money on healthcare) but also would be able to pay less for the insurance. If I ever had a big lawsuit against me, they could actually come and take my house and assets! As it stands right now, we are compensated fairly but as I shared with you at the beginning we are facing another 20% pay-cut not to mention the pay for performance, etc. ways that they are coming up with to not pay us.

Q: Is it easy to get a job after medical school? Is there a high demand for doctors?

A: It depends on the field you go into but yes right now it is fairly easy to get a job. It may not be the one you want and it may not be where you want to live.

Q: Should the U.S. adopt a national healthcare system? If yes, do you think it'll work and why? If no, what are the big consequences the U.S. would face if we did?

A: I am strongly against a national healthcare system. Just to add to it: I think there will be less access to care, I don't think it is affordable and they are still finding ways to ration healthcare without being the bad guy. Case in point: if we do a surgery, there are certain measures that if we don't meet them, the government doesn't pay us or the hospital for the entire surgery. Sounds ok now but let me explain. One of the measures for a heart bypass is that the 30 day mortality (you can't die in the 30 days after your heart bypass), is a trigger to not pay. Obviously, these are big surgeries with lots of risks but this is a death FOR ANY REASON! So, if patient X has a bypass on June first does great and goes home, but three weeks later he is in a car accident and dies, it is considered a death after bypass!! Also, let's say your grandma needs heart surgery but she is not healthy and also has diabetes with kidney failure. We used to take risks on these patients and did surgery to give them a chance. Now if they die within the 30 days, we won't get paid. Looking into the future, do you think a heart surgeon will want to take his pre-op time, 3-4 hours of surgery time, days of seeing the patient in the hospital, follow up in the office, etc. if it is high risk and he won't get paid for it? I think in the future they will start telling patients they are too high of a risk and not do the case because of this. It is a way for the government to ration healthcare without being the bad guy. And the same hold true with post-operative infections. They are 60 days, even if the patient is obese and diabetic

(high risk of infection), if they get an infection then we won't get paid. Guess what, we will eventually quit doing that.

Q: In your opinion what is the best model that the U.S. should adopt as far as healthcare is concerned?

A: I'm not sure how to fix it now. The things that need to be fixed are: get the lawyers to back off so we won't order tests and things to cover our rear, allow employers to provide the same health insurance that they were doing before, spend more money on prevention, don't cut pay but instead offer bonuses for cost savings. Just as another point, people wanted free healthcare, well even if we have complete government healthcare it is not free because you have to pay for the equipment, the workers, etc. That money comes from taxes, therefore you have to pay more taxes and it hurts the working people. People who did not have health insurance could still be treated for free. We have meetings every month and we "write-off" those expenses. If someone writes to us and tells us of their inability to pay, we forgive the debt. If they tell us they can only afford a certain amount, we work with them and decrease their bill. People were getting free healthcare.

Dr. Shannon Sorah attended medical school at West Virginia School of Osteopathic Medicine, Conducted an internship during a transitions year at Allegheny Regional Hospital and conducted her residency in anesthesiology at the University of Tennessee Medical Center at Knoxville. She currently practices at Fort Loudoun Medical Center in Oak Ridge, Tennessee.

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